Supreme Court, U.S.
FILED

(1)

94 969 NOV 30 1994

No.

OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

ROY L. ODEKIRK,
Petitioner,
v.

IMPERIAL PALACE, INC. V.E.B.A. TRUST EMPLOYEE MEDICAL BENEFIT PLAN; IMPERIAL PALACE, INC. V.E.B.A. TRUST AND RALPH ENGELSTAD, AS TRUSTEE; PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,
Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

JOHN A. HUNT, ESQ.
RALEIGH, HUNT & McGARRY, P.C.
302 E. Carson Ave., #1102
Las Vegas, NV 89101
Telephone: (702) 386-4842

Counsel of Record for Petitioner

21 pp

QUESTION PRESENTED

1. Should the "Doctrine of Reasonable Expectations", recently adopted by the Ninth Circuit to apply to ERISA-governed insurance contracts, have been applied in the action below when application of the Doctrine was argued by Petitioner but not considered by the Ninth Circuit?

TABLE OF CONTENTS

	Page
Question Presented	i
Table of Authorities	iii
Opinions Below	1
Jurisdiction	1
Statement of the Case	1
Reasons for Granting the Writ	3
Conclusion	5
Appendix	6

TABLE OF AUTHORITIES

Cases	Page
Saltarelli v. The Bob Baker Group Medical Trust, 35 F.3d 382, 63 USLW 2244 (9th Cir. 1994)	3,5
State Farm Mutual Automobile Insurance Company v. Betty Falness, —F.3d—, 1994 WL 596451, 94 Daily Journal D.A.R. 15492 (9th Cir. 1994)	4
Allstate Insurance Co. v. Ellison, 757 F.2d 1042, 1044 (9th Cir. 1985)	4
Evans v. Safeco Life Ins. Co., 916 F.2d 1437 (9th Cir. 1990)	4
Other Authorities	
Roger C. Henderson, *The Doctrine of Reasonable Expectations and Insurance Law After Two Decades,* 51 Ohio St. L.J. 823 (1990).	4

OPINIONS BELOW

The opinion of the Court of Appeals for the Ninth Circuit is reprinted in the Appendix at 1a. The order of the District Court for the District of Nevada is reprinted in the Appendix at 4a.

JURISDICTION

The Ninth Circuit entered judgment on September 2, 1994 reversing the District Court judgment. This Court has jurisdiction under 28 U.S.C. § 1254 (1) to review the judgment of the Ninth Circuit.

STATEMENT OF THE CASE

In October of 1988, Petitioner Roy L. Odekirk ("Odekirk"), became employed by the Imperial Palace Hotel and Casino ("I.P."). The I.P. offers its eligible employees medical benefits through Respondent Imperial Palace, Inc. V.E.B.A. Trust Employee Medical Benefit Plan ("Plan"). The Plan is an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132 (a) (1) (B). The Plan is administered and self funded by Respondent Imperial Palace V.E.B.A. Trust (the "Plan Administrator"), with a maximum lifetime benefit of $1,000,000.00 for all covered expenses. The Plan Administrator, however, has entered into a deductible Per Covered Unit Stop Loss Agreement with Respondent Provident Life and Accident Insurance Company ("Provident"), which provides for a maximum reimbursement of $950,000.00 after the Plan Administrator has paid the deductible amount of $50,000.00 for covered expense under the Plan.

Odekirk was eligible under the Plan for such medical expenses that were included in the "Covered Expense" provisions of the Plan.

On August 3, 1989, Odekirk was hired to take pictures

of recently installed pool decking at the Las Vegas Hilton for $50.00 per hour. While performing the two hour, free-lance job unrelated to his work at I.P., Odekirk climbed atop a mobile work platform. The platform, as it was being pushed on the ground, toppled throwing Odekirk onto a concrete bench and rendering him a paraplegic. As a result, Odekirk incurred medical bills in excess of $200,000.00.

The Plan Administrator denied Odekirk's claim for the expenses stemming from the fall, citing a clause in the Plan that excludes from coverage "Expense for a work related illness." (App.10a, 11a). Work related illness is defined elsewhere in the Plan as "an illness which arises from or is sustained in the course of work for pay, profit, or gain." (App.9a). Illness is separately defined in the Plan to include "bodily injury." (App.8a).

On January 24, 1991 Odekirk filed action against Respondents in state court alleging Respondents erroneously interpreted the Plan provision to exclude Odekirk's claim for coverage. Respondents removed the suit to federal court pursuant to 28 U.S.C. § 1441.

Cross motions for summary judgment followed. The District Court subsequently granted Odekirk's motion and denied the Respondents' cross motion after determining the exclusionary language was ambiguous, unreasonable and void as against public policy, as interpreted by the Respondents. (App. 6a, 7a).

On appeal, Respondent argued the District Court applied the wrong standard of review and the Plan exclusion was unambiguous. Odekirk countered Respondents' arguments and alternatively argued that even if the exclusion clause was found to be unambiguous, it was still unenforceable based upon the Doctrine of Reasonable Expectations.

On September 2, 1994 the Ninth Circuit reversed the District Court's judgment. The Ninth Circuit held the exclusion provision to be unambiguous. The Ninth circuit reasoned "[the] language of the plan was explicit enough to put an insured layperson on notice that he loses coverage when he performs

outside work for pay." (App. 2a). Based upon the lack of ambiguity, the Ninth Circuit declined to consider whether the District Court applied the appropriate standard of review. (App. 3a).

REASONS FOR GRANTING THE WRIT

In light of new case law recently handed down by the Ninth Circuit in *Saltarelli v. The Bob Baker Group Medical Trust.* 35 F.3d 382, 63 USLW 2244 (9th Cir. 1994), this petition presents an appropriate question for this Court's action. The Ninth Circuit failed to consider the recently adopted "Doctrine of Reasonable Expectations" even though its application was argued by Odekirk.

On August 31, 1994 the Ninth Circuit adopted "the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts." *Saltarelli,* 35 F.3d at 387. Prior to August 31, 1994, the Ninth Circuit received the briefs and entertained oral argument in the instant matter. In his brief, Odekirk argued that even if the Ninth Circuit determined the Plans occupational injury exclusion unambiguously excluded Odekirk from coverage, the exclusion was unenforceable against the petitioner based upon the Doctrine of Reasonable Expectations. At the time Odekirk submitted his argument to the Ninth Circuit, the Doctrine had never been addressed by the Court of Appeals.

The Ninth Circuit's failure to apply the Doctrine to the case below and subsequent adoption of the Doctrine unfairly and unjustly deprived Odekirk of an avenue for success.

Respondents may attempt to argue the Ninth Circuit's neglect was harmless because the Doctrine is merely a rule of construction and thus, is only applied as a test for resolving ambiguities in contracts. Respondents may argue further, the Doctrine was not applicable because no ambiguity was found.

To the contrary, the Doctrine of Reasonable Expectations

"is not merely a rule of construction and may be applied even where there is no ambiguity." Roger C. Henderson, *The Doctrine of Reasonable Expectations and Insurance Law After Two Decades*, 51 Ohio St. L.J. 823 (1990). Moreover, the Ninth Circuit has recently applied the Doctrine in the absence of ambiguous policy language. See *Saltarelli, supra* and *State Farm Mutual Automobile Insurance Company vs. Betty Falness*, —F.3d—, 1994 WL 596451, 94 Daily Journal D.A.R. 15492 (9th Cir. 1994).

Odekirk would have been successful in the court below under the reasonable expectations doctrine. There was an objective basis for Odekirk's belief the Plan would cover an injury that occurred while he was "moonlighting" as a photographer. The exclusion itself is for "Expense for a work related illness." (App.10a) To the layman an illness is a sickness. ERISA plan terms are to be interpreted "in an ordinary and popular sense as would a [person] of average intelligence and experience. "*Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985), cited in *Evans v. Safeco Life Ins. Co.*, 916 1437 (9th Cir. 1990). To truly understand the exclusion, it requires a coordinated reading of two separate definitions: those for "illness" and "work related illness", found on pages 8 and 10 of the policy as opposed to page 42 where the exclusion language is located. The plan exclusion can only be understood after the kind of painstaking study a reasonable insured would not be expected to undertake.

Likewise, the circumstances surrounding the acquisition and issuance of the insurance policy affirms Odekirk's reasonable expectations of coverage. Because the exclusion in question is part of a group policy provided as a benefit of employment with Respondent, and workmen's compensations covers injuries arising out of that employment, it is reasonable for Odekirk to surmise the exclusion refers to work done on behalf of the Respondent, not other work yielding remuneration.

CONCLUSION

Based upon the recent ruling by the Ninth Circuit in *Saltarelli, supra*, which adopted the Doctrine of Reasonable Expectations, Odekirk submits the petition for writ of certiorari should be granted.

Respectfully submitted,

John A. Hunt, ESQ.
Raleigh, Hunt & McGarry, P.C.
302 E. Carson Ave., #1102
Las Vegas, NV 89101
Telephone: (702) 386-4842

Counsel of Record for Petitioner

APPENDIX

Not for Publication
United States Court of Appeals
For the Ninth Circuit

Imperial Palace, Inc. V.E.B.A. Trust Employee Medical Benefit Plan; Imperial Palace, Inc., V.E.B.A. Trust and Ralph Engelstad as Trustee; Provident Life and Accident Insurance Company,	)	**FILED** SEP 02 1994 CATHY A. CATTERSON, CLERK U.S.COURT OF APPEALS
Defendants-Appellants,	)	No. 93-15229 No. CV 91-00118-LOG
v.	)	**MEMORANDUM***
Roy L. Odekirk,	)	
Plaintiff-Appellee.	)	

Appeal from the United States District Court
for the District of Nevada
Lloyd D. George, District Judge, Presiding
Argued and Submitted August 12, 1994
San Francisco, California

Before: NORRIS, THOMPSON, and TROTT, CIRCUIT JUDGES

Roy Odekirk was employed by Imperial Palace and covered under its employee benefit plan ("the Plan"). While performing a two-hour freelance job not related to his work at Imperial, Odekirk fell off a moving platform and was rendered paraplegic.

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Circuit Rule 36-3.

The Plan refused to pay Odekirk's medical bills, citing to a provision of the Plan which excluded benefits for "work-related illness." Odekirk filed a claim in federal court pursuant to 29

U.S.C. § 1132 (a) (1) (B) of the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA") against defendants to challenge the denial of benefits. The district court issued summary judgment for the plaintiff. Defendants now appeal. We have jurisdiction pursuant to 28 U.S.C. § 1291. We reverse.

We review determinations of whether the administration of a plan comports with ERISA de novo. Williams v. Caterpillar, Inc., 944 F.2d 658, 661 (9th Cir. 1991). In this case, the district court found that the Plan exclusion for "work-related illness" was ambiguous. The district court reasoned that , at first reading, the "work-related illness provision" appeared only to address double recovery for worker's compensation. The language was not explicit enough, therefore, to put a reasonable insured layperson on notice that he loses benefits when he performs any outside work for pay, no matter how slight. Because of this ambiguity, the district court construed the Plan is favor of the insured. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 540 (9th Cir. 1990).

We disagree. The Plan excluded benefits for "work-related illness," which was defined to include "bodily injury" which "arises form or is sustained in the course of work for pay, profit or gain." ER tab 24, Exh. "F" at 8, 10, & 42. The language is unambiguous. Odekirk did sustain bodily injury in the course of work for pay. His injury, therefore, falls directly within the scope of uncovered expenses. Furthermore, "work-related illness" language did not address the problem of double recovery because a separate provision covered worker's compensation. Id. at 41. The language of the Plan was explicit enough to put an insured layperson on notice that he loses coverage when he performs outside work for pay.

Because the phrase "work-related illness" as explicitly defined is unambiguous, we need not reach the question of whether the district court erred in reviewing the Plan Administrator's interpretation of the Plan de novo rather than applying an abuse of discretion standard.

Reversed.

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

Roy L. Odekirk,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CV-S-91-118-LDG (RJJ)
	)	
Imperial Palace, Inc. V.E.	)	
B.A. Trust Employee Medical	)	
Benefit Plan, et at.,	)	
	)	
Defendants.	)	

ORDER

This matter is before the court on the parties' cross-motions for summary judgment (#24 & #27).

1. Facts

The following facts are undisputed. In 1989 the plaintiff, Roy Odekirk, was employed by the Imperial Palace as a stage-hand. As an employee, he was covered by the Imperial Palace's employee benefit plan ("the Plan"). In August of that year Odekirk agreed to do some free-lance photography work for a construction firm for $100. This work was unrelated to his employment at the Imperial Palace. While Odekirk was taking photographs from a moving platform, the platform collapsed and he was thrown onto a concrete bench, rendering him a paraplegic. Odekirk has incurred approximately $235,000 in medical expenses as a result of this injury.

The Plan insurance company has refused to pay any part of these expenses, relying on the following provision of Odekirks' policy:

Covered expense does not include

• • •

Expense for a work related illness
(emphasis in the original).

"Work related illness" is defined elsewhere in the policy as "an illness which arises from or is sustained in the course of work for pay, profit or gain (emphasis in the original). "Illness," also separately defined in the policy, includes "bodily injury or sickness." The Plan denied coverage on the grounds that Odekirks' injury was a "work-related illness" (as defined in the policy"), i.e. a "bodily injury" he sustained "in the course of work for pay, profit or gain." Under the Plan's theory, expenses arising out of that injury are excluded under the policy.

Odekirk argues that he should be able to recover from the Plan on three theories: 1) he argues that the plan exclusion is ambiguous and should be construed in favor of the insured, 2) he argues that the purpose of the exclusion clause in question is only to prevent double recovery and, since Odekirk is not entitled to workmen's compensation with respect to his injury, the exclusion does not apply, and 3) he argues that the Plan's interpretation of the exclusion clause is unreasonable and, consequently, unenforceable as against public policy.

The Plan argues that 1) the plan trustee's interpretation of the policy should be given deference, 2) the policy clearly and unambiguously excludes Odekirk's injury from coverage, 3) the purpose of the exclusion is not solely to prevent double recovery to persons already covered by workmen's compensation, since that contingency is dealt with in a separate policy exclusion, and 4) the Plan's interpretation of the policy is reasonable and not against public policy.

2. Law

There is no Nevada case law on point. The cases are split among most other jurisdictions on these issues. Some courts have held that exclusion clauses similar to the one at issue in this case are inherently ambiguous because they appear, at first reading, to be designed only to prevent double recovery (in cases where workmen's compensation is available). See Phillips v. Utah Local Government's Trust, 660 P.2d 249 (Utah 1983);

Carrol v. Union Labor Life Insurance Company, 65 Wash.2d 513, 398 P.2d 164 (1965). These courts have found that no reasonable insured in Odekirk's place could have anticipated from reading the exclusion clause that, as soon as the insured began engaging in "moonlighting" activity (however slight), all of his/her health benefits ceased with respect to injuries sustained as a result of that activity. Also see Segelstrom v. Blue Shield of Florida, Inc., 233 So.2d 645 (Fl.2d DCA 1970) and United Benefit Life Insurance Company of Omaha v. Glisson, 105 Ga.App. 122, 123 So.2d 350 (1961).

Other courts have found the same types of exclusion clauses unambiguous and have upheld the insurers' denial of coverage. See Kaczmarck v. Provident Life & Accident Insurance Company, 747 F.Supp. 516 (E.D. Ark. 1990); Brezan v. Prudential Insurance Company of America, 507 F.Supp. 962 (E.D. Pa. 1981); Sheperd v. Crown Life Insurance Company, 308 N.E.2d 672 (Ill. App. 1974). These courts have read similar policy provisions literally and found that, technically, they do exclude coverage to moonlighters who are injured while they are moonlighting.

None of these cases are binding on the court. Nevada courts generally construe ambiguous insurance policies in favor of the insured. See National Union Fire Ins. Co. of State of Pa., Inc. v. Reno's Executive Air, Inc., 100 Nev. 360, 682 P.2d 1380 (1984). The court finds that the insurance company probably designed the exclusion provision to apply to situations like Odekirk's, and not just to prevent double recovery. However, in the court's view the provision is ambiguous because it can only be understood to mean what the defendants say it means when it is closely parsed and viewed in the light of hindsight. It is not explicit enough to put a reasonable insured layman on notice that he/she loses insurance benefits whenever he/she does any outside work for pay, no matter how minor.

It should be remembered that the policy in this case is essentially an adhesion contract, written by the defendants in language of their own choosing. If the defendants had wanted

to make absolutely clear their intent, they could have done so. The court must presume that the drafters of the policy were aware of the line of cases finding exclusion clauses of this type ambiguous. The drafters of the policy could have chosen to make the exclusion much more clear, in light of these cases.

The court further finds that the defendants' interpretation of the exclusion leads to an unfair and unreasonable result, and therefore cannot, as a matter of public policy, be sustained. When an insurance policy has been issued which purportedly provides coverage but whose exclusionary provisions would narrow the coverage to defeat the purpose of the insurance, the policy must be construed against the insurer. National Union Fire Ins. Co. of State of Pa., Inc. v. Reno's Executive Air, Inc., 100 Nev. 360, 682 P.2d 1380 (1984). In this case the exclusion, as interpreted by the defendants, applies as soon as an insured begins performing any task, however small, for which he/she would be compensated. While it may be reasonable to expect an insured to obtain supplemental insurance if he/she enters into fairly regular supplemental employment, it is unreasonable to expect an insured to be aware that his/her insurance benefits need to be supplemented the moment he/she begins performing the smallest of odd jobs for pay. Therefore, the court finds 1) that the defendants' interpretation of the exclusion is not entitled to deference and 2) that the exclusion, as interpreted by the defendants in this case, is unreasonable and void as against public policy.

Accordingly, for the reasons above stated,

IT IS ORDERED that the defendant's motion for summary judgment (#24) is denied;

IT IS FURTHER ORDERED that plaintiff's cross-motion for summary judgment (#27) is granted as to the issue of liability on the insurance policy in this case.

Date: 17 June 1992

Lloyd D. George
United States District Judge

Illness Means:

(1) Bodily injury or sickness; or
(2) Pregnancy, childbirth, or a condition which arises from either; or
(3) Congenital defects or birth abnormalities, including premature birth

for which more than routine nursery care is required.

Mandated Continuation means the time span next following the date Medical or Dental Benefits would have ceased during which time such coverage may be continued as allowed by law.

of osteopathy, provides services which are covered by the *Plan;* and (2) Is practicing within the scope of his or her license.

Pre-existing Condition means an illness which is first sustained prior to the person's effective date of coverage and for which treatment or advice was given or expense was incurred within the 90 days preceding such effective date.

Prosthesis means any full or partial removable denture, crown or fixed bridge.

Time Effective. When any date is referred to, the effective time shall be 12:01 A.M. at the address of the *Plan* Administrator.

Totally Disabled and Total Disability mean being unable, because of illness:

(1) To work for pay, profit, or gain at any job for which one is suited by reason of education, training or experience; or

(2) To engage in one's regular and usual activities and not working at any job for pay, profit, or gain.

Item (1) applies to each person who is covered as *a full* time *employee.*
Item (2) applies to all other covered persons, if any.

Treatment Facility means a place certified as such by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources.

Work Related Illness means an *illness* which arises from or is sustained in the course of work for pay, profit, or gain.

Home health care includes: (1) Skilled nursing care and home health aide services; and (2) Any other services and supplies provided in lieu of the services which would have been covered under the Plan if the *covered person* was confined in a *hospital* or nursing *home*. Home health care does not include housekeeping or custodial care.

Covered Expense for licensed ambulance service is limited to expense incurred to transport a *covered* person to the nearest facility qualified to treat the illness of such person.

Covered Expense for a diabetes instruction program which is: (1) Designed to teach the patient and his or her family about the disease process and the daily management of diabetic therapy; and (2) Supervised by a *doctor.* Total payment for such Covered Expense will not exceed $100 per *calendar* year.

• Drugs or medicines which can be obtained only with a doctor's prescription.

• Oxygen.

• Artificial limbs or eyes, and other non-dental prosthetic devices.

• Rental or, on approval, the purchase of durable medical equipment which is designed and used only for the treatment of illness.

An expense is deemed to be incurred on the date the service is performed or the supply is obtained.

Covered Expense Does Not Include:

• Supplies or services for which no charge is made or for which the covered person is not required to pay.
• Supplies and services which the covered person is entitled to receive from the Uniformed Services Medical Care Facilities.

• Expense for which the covered person has or had a right to payment under: (1) A workers' compensation or similar law; or (2) A program of a government or plan established by law, except: (A) *Medicare;* (B) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and (C) Where the law does not permit this type of exclusion.

• Expense for a *work related illness.*

• Expense for cosmetic surgery unless performed to repair: (1) A birth defect; or (2) Damage due to an accident which occurred while covered for these benefits, provided the expense is incurred while so covered, but no later than two years after the date of the accident.

• Expense for the services of a person who normally lives in your household, or who is the parent, spouse, child, brother or sister of you or your dependent.

Expense incurred while coverage is not in force, except as provided under the terms of the **Extension of Benefits During Disability** section.

• Expense for any of the services listed below unless, and except to the extent that, specific provisions dealing with such services are included in the *Plan.*

Supreme Court, U.S.
FILED
DEC 28 1994
OFFICE OF THE CLERK

No. 94-969

In The

Supreme Court of the United States

October Term, 1994

ROY L. ODEKIRK,

Petitioner,

v.

IMPERIAL PALACE, INC. V.E.B.A. TRUST EMPLOYEE MEDICAL BENEFIT PLAN; IMPERIAL PALACE, INC. V.E.B.A. TRUST AND RALPH ENGELSTAD, AS TRUSTEE; PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

JAMES H. WALTON, ESQ.
NITZ, WALTON & HEATON
514 S. Third Street
Las Vegas, NV 89101
(702) 474-4004

Counsel of Record for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the "doctrine of reasonable expectations" recently adopted by the Ninth Circuit applies to an ERISA-governed employee medical benefit plan which contains unambiguous exclusionary language.

2. Whether the ERISA-governed employee medical benefit plan in the case at bar satisfied the "doctrine of reasonable expectations" as adopted by the Ninth Circuit.

3. Whether the Ninth Circuit took into consideration the Petitioner's argument regarding the application of the "doctrine of reasonable expectations" in reaching its decision.

4. Whether this Court should grant certiorari to review questions regarding a doctrine which has not yet been fully developed by the Ninth Circuit and which involve no important issues of federal law or conflicts between the Circuits.

RULE 29.1 LIST

Respondent, Provident Life and Accident Insurance Company, has a parent company by the name of Provident Life and Accident Insurance Company of America which is publicly traded.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

RULE 29.1 LIST ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES v

I. STATEMENT OF THE CASE 2

II. REASONS FOR DENYING WRIT 2

A. SUMMARY 2

B. THE "DOCTRINE OF REASONABLE EXPECTATIONS" RECENTLY ADOPTED BY THE NINTH CIRCUIT DOES NOT APPLY TO AN ERISA-GOVERNED EMPLOYEE MEDICAL BENEFIT PLAN WHICH CONTAINS UNAMBIGUOUS EXCLUSIONARY LANGUAGE 4

C. EVEN IF THE DOCTRINE APPLIES, THE ERISA PLAN IN THE PRESENT CASE SATISFIED THE DOCTRINE AS ADOPTED BY THE NINTH CIRCUIT 8

D. IN REACHING ITS DECISION, THE NINTH CIRCUIT TOOK INTO CONSIDERATION THE PETITIONER'S ARGUMENT REGARDING THE APPLICATION OF THE DOCTRINE 11

TABLE OF CONTENTS – Continued

Page

E. THE NINTH CIRCUIT HAS NOT YET DEVELOPED THE SCOPE OF THIS RECENTLY ADOPTED DOCTRINE, THEREFORE, CERTIORARI SHOULD NOT BE GRANTED TO REVIEW QUESTIONS REGARDING THE DOCTRINE WHICH DO NOT INVOLVE IMPORTANT ISSUES OF FEDERAL LAW OR CONFLICTS BETWEEN THE CIRCUITS 12

III. CONCLUSION 15

APPENDIX 1a

TABLE OF AUTHORITIES

Page

CASES

Arley v. Liberty Mutual Fire Insurance Company, 85 Nev. 541, 458 P.2d 742 (1969) 7

Braxton v. U.S., 111 S.Ct. 1854, 114 L.Ed.2d 385 (1991) 13, 14

John Simmons Co. v. Grier Bros. Co., 258 U.S. 82, 42 S.Ct. 196, 66 L.Ed. 475 (1922) 7

Meester v. IASD Health Services Corp., 963 F.2d 194 (8th Cir. 1992) 5, 13

National Mutual Insurance Co. v. McMahon & Sons, Inc., 177 W. Va. 734, 356 S.E.2d 486 (1977) 5

Pitts v. American Security Life Insurance Company, 931 F.2d 351 (5th Cir. 1991) 5, 13

Rice v. Sioux City Memorial Park Cemetery, 349 U.S. 70, 75 S.Ct. 614, 99 L.Ed. 897 (1955) 14

Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382 (9th Cir. 1994) ..... *passim*

Scotten v. Littlefield, 235 U.S. 407, 35 S.Ct. 125, 59 L.Ed. 289 (1914) 7

State Farm Mutual Automobile Insurance Company v. Betty Falness, ___ F.3d ___, 1994 WL 596451, 94 Daily Journal D.A.R. 15492 (9th Cir. 1994) 4, 6, 7

RULES:

Rule 10, Rules of the Supreme Court 13

Rule 61, Federal Rules of Civil Procedure 7, 11

No. 94-969

In The

Supreme Court of the United States

October Term, 1994

ROY L. ODEKIRK,

Petitioner,

v.

IMPERIAL PALACE, INC. V.E.B.A. TRUST EMPLOYEE MEDICAL BENEFIT PLAN; IMPERIAL PALACE, INC. V.E.B.A. TRUST AND RALPH ENGELSTAD, AS TRUSTEE; PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

TO THE HONORABLE SUPREME COURT:

Imperial Palace, Inc. V.E.B.A. Trust Employee Medical Benefit Plan; Imperial Palace, Inc. V.E.B.A. Trust and Ralph Engelstad, as Trustee; and Provident Life and Accident Insurance Company, Respondents, respectfully submit this brief in opposition to the Petition for Writ of Certiorari to the United States Court of Appeals for the

Ninth Circuit, filed herein by Petitioner, Roy L. Odekirk, and received by Respondents on November 30, 1994.

I

STATEMENT OF THE CASE

Respondents' adopt Petitioner's Statement of the Case on pages 1 through 3 of the Petition for Writ of Certiorari ("Petition"), except for the inaccuracies and/or omissions which Respondents' correct hereinbelow.

The quoted portions from the Imperial Palace, Inc. V.E.B.A Trust Employee Medical Benefit Plan ("Plan") on page 2 of the Petition are inaccurate insofar as the definitional terms and phrases used therein are not italicized. The proper quotes are as follows: "Expense for a *work related illness*"; and "an *illness* which arises from or is sustained in the course of work for pay, profit, or gain."

In identifying what arguments were presented on appeal to the Ninth Circuit on page 2 of the Petition, the Petitioner omitted the fact that Respondents countered his alternative argument concerning the application of the doctrine of reasonable expectations. The inclusion of this fact is important to show that the issue on the doctrine's application was fully briefed before the Ninth Circuit.

II

REASONS FOR DENYING WRIT

A. SUMMARY

The Petitioner contends that the doctrine of reasonable expectations (adopted by the Ninth Circuit two days

before the decision in the case at bar was entered) applies to the present case but erroneously was never addressed by the Ninth Circuit.

Respondents rebut this contention on several grounds. First, Respondents argue that the doctrine does not apply. This argument is based on the premise that the Ninth Circuit adopted the doctrine of reasonable expectations as merely a rule of construction to be applied only as a means of resolving ambiguities in ERISA-governed contracts. Since the Ninth Circuit found the language in Respondents' ERISA-governed Plan to be unambiguous, there was no need for the Circuit to apply the doctrine.

Secondly, Respondents argue that even if the Ninth Circuit adopted the doctrine as more than a rule of construction, the ERISA-governed Plan in the present case satisfies the requirements as outlined by the Ninth Circuit in the recent decision in which the doctrine was adopted.

Under the circumstances of either of Respondents' first two arguments, any failure of the Ninth Circuit to consider the application of the doctrine would merely constitute harmless error.

Thirdly, Respondents' alternatively argue that the Ninth Circuit did in fact consider the Petitioner's argument concerning the application of the doctrine despite the fact that the Circuit's memorandum did not expressly acknowledge the doctrine by name as a basis for its conclusion.

Finally, Respondents argue that this case presents no issue appropriate for the exercise of this Court's jurisdiction insofar as there is no important question of federal

law or conflict among the circuits presented by the facts of this case which requires adjudication or clarification.

B. THE "DOCTRINE OF REASONABLE EXPECTATIONS" RECENTLY ADOPTED BY THE NINTH CIRCUIT DOES NOT APPLY TO AN ERISA-GOVERNED EMPLOYEE MEDICAL BENEFIT PLAN WHICH CONTAINS UNAMBIGUOUS EXCLUSIONARY LANGUAGE

Respondents do not dispute that the Ninth Circuit recently rendered a decision in which it adopted "the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts". *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994). Respondents do, however, take issue with Petitioner's application of that doctrine to the present case.

Petitioner claims that the doctrine is more than a rule of construction and that it may be applied when no ambiguities exist in the language of an ERISA-governed insurance contract. The Petitioner relies on two Ninth Circuit cases to support this proposition, *Saltarelli, supra,* and *State Farm Mutual Automobile Insurance Company v. Betty Falness,* ___ F.3d ___, 1994 WL 596451, 94 Daily Journal D.A.R. 15492 (9th Cir. 1994).

Petitioner's reliance on *Saltarelli* is misplaced. Petitioner mischaracterizes the law in *Saltarelli* by saying the Ninth Circuit applied the doctrine of reasonable expectations in the absence of ambiguous policy language.

In *Saltarelli, supra,* the Ninth Circuit agreed with the lower court that the exclusionary language at issue was

not clear or plain. *Id.* 35 F.3d at 385, 387. In effect, the Court was saying the exclusionary language was ambiguous. Clearly, this was not a case in which the Ninth Circuit initially found such language to be unambiguous, but decided to apply the doctrine of reasonable expectations despite such clear, plain, and unambiguous language, as Petitioner suggests.

Respondents submit that the Ninth Circuit's adoption of the doctrine of reasonable expectations in *Saltarelli*, as a principle of uniform federal law, was merely as a rule of construction to be applied when language in ERISA-governed plans is ambiguous. The Ninth Circuit's analysis leading up to the adoption of this doctrine supports this conclusion. First, the Ninth Circuit acknowledges that the doctrine "grew out of the law of adhesion contracts and construction of ambiguities in insurance policies". *Id.* 35 F.3d at 386. The Ninth Circuit then quotes from *National Mutual Insurance Co. v. McMahon & Sons, Inc.*, 177 W. Va. 734, 356 S.E.2d 486 (1977), a case which indicates the doctrine will only be applied to enforce liability against an insurer when its policy exclusions are not conspicuous, plain, and clear. *Id.* 35 F.3d at 386. Finally, the Ninth Circuit refers to two other circuit cases which have touched on the issue of application of the reasonable expectations doctrine. *Id.* 35 F.3d at 386, note 5.

In this regard, the Eighth Circuit found that since the ERISA contract at issue contained no ambiguities, there was no occasion to apply the doctrine of reasonable expectations. *Meester v. IASD Health Services Corp.*, 963 F.2d 194, 197 (8th Cir. 1992). The Fifth Circuit's reference to this doctrine was more indirect. In *Pitts v. American*

Security Life Insurance Company, 931 F.2d 351 (5th Cir. 1991), the Fifth Circuit agreed with the lower court that the insured's reasonable expectation of continued coverage was one of several reasons supporting the holding that the policy therein was voidable rather than void. *Id.* 931 F.2d at 355-356. Coverage was also allowed on the basis of waiver.

The foregoing analysis used by the Ninth Circuit in reaching its decision to adopt the reasonable expectations doctrine, together with the language used by the Ninth Circuit when actually applying the doctrine (i.e. that the exclusionary language must be "clear, plain and conspicuous" (*Saltarelli, supra*, at 387) to avoid application of the doctrine), supports the conclusion that the Ninth Circuit intended to adopt this doctrine as merely a rule of construction to be used when interpreting an ERISA-governed contract.

Petitioner's reliance on *State Farm Mutual Automobile Insurance Company v. Betty Falness*, ___ F.3d ___, 1994 WL 596451, 94 Daily Journal D.A.R. 15492 (9th Cir. 1994) is also misplaced. *Falness* is wholly inapplicable to the case at bar for three reasons. First, in *Falness*, the Ninth Circuit was reviewing a decision involving a coverage issue under an automobile liability insurance policy. The insurance policy being reviewed was not governed by ERISA, state law was not preempted, and therefore, the uniform federal common law was not applicable. To the contrary, the Ninth Circuit in *Falness* relied solely on Arizona state law in determining whether and to what extent the doctrine of reasonable expectations applied. Thus, the scope of the doctrine, as applied in *Saltarelli*, was in no way

effected by the Ninth Circuit's decision in *Falness*. Secondly, unlike the instant case, the contract provisions in *Falness* were ambiguous and unclear. Thirdly, the decision in *Falness* was rendered on November 2, 1994, after the decision in the case at bar was entered. A change in judicial view of the applicable law, after entry of final judgment, is not a basis for vacating a judgment entered before the change. *Arley v. Liberty Mutual Fire Insurance Company*, 85 Nev. 541, 458 P.2d 742 (1969); *John Simmons Co. v. Grier Bros. Co.*, 258 U.S. 82, 42 S.Ct. 196, 66 L.Ed. 475 (1922); *Scotten v. Littlefield*, 235 U.S. 407, 35 S.Ct. 125, 59 L.Ed. 289 (1914).

In the present case, Petitioner was denied coverage under Respondent, Imperial Palace, Inc. V.E.B.A. Trust Employee Medical Benefit Plan ("Plan") due to a provision under the Plan which provided: "**Covered Expense Does Not Include:** Expense for a *work related illness*." (Petitioner's Appendix 11a) The Ninth Circuit found this exclusionary language to be unambiguous. (Petitioner's Appendix 2a and 3a) Therefore, the doctrine of reasonable expectations was inapplicable. There simply was no occasion for the Ninth Circuit to address Petitioner's argument regarding that doctrine's application. Thus, any error attributed to the Ninth Circuit for its failure to do so, is harmless. See Rule 61, Federal Rules of Civil Procedure.

C. EVEN IF THE DOCTRINE APPLIES, THE ERISA PLAN IN THE PRESENT CASE SATISFIED THE DOCTRINE AS ADOPTED BY THE NINTH CIRCUIT

Even if this Court were to accept Petitioner's argument that the Ninth Circuit adopted the doctrine of reasonable expectations as more than a rule of construction which may be applied in the absence of ambiguous policy language, the Respondents submit that the Plan's exclusionary language satisfies the doctrine set forth in *Saltarelli, supra.*

Petitioner contends that the doctrine applies because a "painstaking study" is required in order for an employee to understand the Plan exclusion. This contention is absurd. From the very beginning, the Plan's introduction spells out in plain language that the first section gives definitions to be used throughout. (Respondents' Appendix 3a) The Plan further states that when a word is *italicized* (providing an illustration of what italicized means by actually putting that word in italics), that means it is a defined term. (Respondents' Appendix 3a) The Plan's provisions for medical expense coverage state specifically which expenses are covered and which are not. (Respondents' Appendix 4a and Petitioner's Appendix 11a) These lists are preceded by bold type headings indicating the same. Furthermore, the first sentence under the "Covered Expenses" heading begins with a disclaimer that states: "Subject to the section entitled **Covered Expenses Does Not Include** [which is in bold print], Covered Expenses shall include . . . " (Respondents' Appendix 4a) The actual exclusion involved herein is *"work related illness"* which is italicized, thus directing

the reader to look at the definitions. (Petitioner's Appendix 11a) A very simplistic approach indeed.

Not only is the applicable exclusion clearly set forth in the section on exclusions in the Plan entitled "**Covered Expenses Does Not Include**", but the Petitioner is immediately put on notice of this section in the Plan's Table of Contents. (Respondents' Appendix 1a and 2a) It defies logic to contend that a "painstaking study" is required to understand the meaning of the exclusion.

Basically, Petitioner is asserting that his reasonable expectation regarding the Plan exclusion for "*work related illness*" was that such an exclusion wouldn't apply because he would not expect the word "*illness*" to include "bodily injury". However, if you follow this line of reasoning to its logical end and thereby presume Petitioner won't read the Plan's definitions, then it's also safe to assume that Petitioner had no reasonable expectation that he would be covered by the Plan, since the Plan only covers expenses for those services and supplies which are furnished for diagnosis and treatment of an "*illness*" (Respondents' Appendix 4a), and Petitioner's condition resulted from bodily injury.

Petitioner also argues that it was reasonable for him to surmise that the *work related illness* exclusion (excluding injuries sustained in the course of work for pay, profit or gain) refers only to work for the Imperial Palace which would be covered by worker's compensation. However, the *work related illness* exclusion was contained in an entirely separate paragraph than the exclusion for injuries covered by worker's compensation (Petitioner's Appendix 11a). Regarding this issue, the Ninth Circuit

expressly noted that " . . . a separate provision covered worker's compensation". (Petitioner's Appendix 2a). It would therefore not be logical or reasonable to conclude that the two separate and distinct exclusions were the same.

The foregoing analysis of the exclusion in the present case demonstrates how greatly it differs from the exclusion analyzed in *Saltarelli, supra.* In *Saltarelli,* the plan's Table of Contents provided no reference to a section in the body of the plan regarding exclusions. *Id.* 35 F.3d at 385. In addition, although a subsection entitled "Exclusions and Limitations" was included in the plan, there was no mention in that subsection of the particular exclusion at issue. *Id.* The exclusion at issue was for "pre-existing conditions" and it could only be found in the midst of the "Definitions" chapter. Furthermore, the definitions provided for the phrase "pre-existing conditions", were not plain or clear. Therefore, the Ninth Circuit found that the "exclusion was not clear, plain and conspicuous enough to negate layman Saltarelli's objectively reasonable expectations of coverage". *Id.* 35 F.3d at 387.

In the present case, not only was the exclusion for *"work related illness"* conspicuously placed in the Plan, but the Ninth Circuit specifically found that it was explicitly defined and that overall it "was explicit enough to put an insured layperson on notice that he loses coverage when he performs outside work for pay". (Petitioner's Appendix 2a and 3a).

Clearly, the requirements of the doctrine of reasonable expectations adopted by the Ninth Circuit have been satisfied and therefore, the exclusionary language in the

Plan is enforceable. Thus, even if the Ninth Circuit did not specifically address Petitioner's argument regarding the application of the doctrine, (a point Respondents dispute in the argument set forth hereinbelow) it was merely harmless error given the fact that the requirements of the doctrine were satisfied. See Rule 61, Federal Rules of Civil Procedure.

D. IN REACHING ITS DECISION, THE NINTH CIRCUIT TOOK INTO CONSIDERATION THE PETITIONER'S ARGUMENT REGARDING THE APPLICATION OF THE DOCTRINE

Based upon the language used by the Ninth Circuit in analyzing the exclusionary language under the Plan, Respondents alternatively argue that the Petitioner's argument concerning the application of the doctrine of reasonable expectations was taken into consideration by the Circuit Court when reaching its decision in the case at bar.

In addressing the district court's determination that "[t]he language was not explicit enough . . . to put a *reasonable* [emphasis added] insured layperson on notice that he loses benefits when he performs any [emphasis in original] outside work for pay, no matter how slight", the Ninth Circuit specifically held that the language of the Plan was in fact "explicit enough to put an insured layperson on notice that he loses coverage when he performs outside work for pay". (Petitioner's Appendix 2a) As noted above, the Ninth Circuit also rejected the Petitioner's argument that it was reasonable for him to surmise that the exclusion was a worker's compensation

exclusion, since that exclusion was stated in a separate paragraph. The Ninth Circuit further held that the phrase *"work related illness"* was explicitly defined and therefore unambiguous. (Petitioner's Appendix 3a)

The Ninth Circuit's determination in the present case fully comports with its decision in *Saltarelli, supra.* The language employed by the Ninth Circuit in the present case imports the same meaning as the language used by the Ninth Circuit in *Saltarelli*; i.e., that the Plan's exclusion was "clear, plain, and conspicuous enough" to negate an insured layperson's objectively reasonable expectations of coverage.

The issue regarding the application of the doctrine of reasonable expectations was not only fully briefed, but was argued by Petitioner and Respondents to the Ninth Circuit and apparently was considered by the Ninth Circuit in its decision.

E. THE NINTH CIRCUIT HAS NOT YET DEVELOPED THE SCOPE OF THIS RECENTLY ADOPTED DOCTRINE, THEREFORE, CERTIORARI SHOULD NOT BE GRANTED TO REVIEW QUESTIONS REGARDING THE DOCTRINE WHICH DO NOT INVOLVE IMPORTANT ISSUES OF FEDERAL LAW OR CONFLICTS BETWEEN THE CIRCUITS

This Court should only grant a petition for writ of certiorari when a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter; has decided a federal question in a way that conflicts

with applicable decisions of this Court; or when the case involves an important question of federal law which has not been, but should be, settled by this Court. Rule 10, Rules of the Supreme Court (Jan. 1, 1990).

Since this Court has never addressed the issue of whether the doctrine of reasonable expectations should be applied when interpreting ERISA-governed plans, the Ninth Circuit's decision to adopt the doctrine in this context in no way conflicts with any applicable decisions of this Court.

Furthermore, there doesn't appear to be any conflict among the circuit courts. In addition to the Ninth Circuit, there are only two other circuits that have even touched on this issue. The Eighth Circuit has indicated that it would apply the doctrine of reasonable expectations to an ERISA-governed contract as a rule of construction to resolve ambiguities. *Meester v. ISAD Health Services Corp.*, 963 F.2d 194, 197 (8th Cir. 1992). Additionally, while the Fifth Circuit uses the phrase "reasonable expectations" in its decision it does not refer to it as a doctrine being applied in the ERISA context or otherwise. *Pitts v. American Security Life Insurance Company*, 931 F.2d 351, 355-356 (5th Cir. 1991). The case was also decided on other grounds, and does not explain the Circuit's interpretation of the scope of the doctrine.

The Ninth Circuit adopted the doctrine of reasonable expectations as a principle of the uniform federal common law, to be applied when interpreting ERISA-governed insurance contracts. Neither the Eighth Circuit nor the Fifth Circuit have refused to adopt this doctrine, therefore, these circuits are not in conflict with the Ninth

Circuit's holding in *Saltarelli, supra*. This Court has previously held that "[a] principal purpose for which we use our certiorari jurisdiction . . . is to resolve conflicts among the Circuit Court of Appeals . . . concerning the meaning of provisions of federal law." *Braxton v. U.S.*, 111 S.Ct. 1854, 114 L.Ed.2d 385 (1991).

Finally, the present case does not involve a question of federal law significant enough to warrant review by this Court. Although the Ninth Circuit adopted the doctrine of reasonable expectations as a principle of the uniform federal common law, the Circuit expressly left the "comprehensive delineation of the doctrine's scope to future cases". *Saltarelli*, 35 F.3d at 387, n.8. Thus, even the Ninth Circuit recognizes that this newly created federal law needs to be more fully developed.

The issue regarding the doctrine's application to the Petitioner in this case is not ripe for review by this Court. This Court does not sit for the benefit of the particular litigants. *Rice v. Sioux City Memorial Park Cemetery*, 349 U.S. 70, 75 S.Ct. 614, 99 L.Ed. 897 (1955). Rather, it grants review only when there are special and important reasons therefor, which implies a reach to a problem beyond the academic or the episodic. *Id.*

Based on the foregoing, there is no reason for this Court to grant certiorari.

III

CONCLUSION

Respondents respectfully request that this Court deny the Petition for Writ of Certiorari because the case presents no issue appropriate for the Court's review insofar as (1) no prejudicial error was committed by the Ninth Circuit; and, (2) no important question of federal law or conflict among the circuits requires adjudication or clarification.

DATED: December 28, 1994.

Respectfully Submitted:

JAMES H. WALTON
NITZ, WALTON & HEATON
514 South Third Street
Las Vegas, NV 89101
(702) 474-4004

Counsel of Record
for Respondents

TABLE OF CONTENTS

Page

INTRODUCTION 3

PROVISIONS APPLICABLE TO ALL COVERAGES 5

DEFINITIONS 6

WHEN COVERAGE STARTS
For You 11
For Dependents 12

WHEN COVERAGE STOPS 15

BENEFITS UNDERWRITTEN BY PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY 19

PLAN SUMMARY 21

LIFE INSURANCE FOR YOU 22
Life Insurance Conversion Right For You 22
Extension of Life Insurance While Totally Disabled 24

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU 26

BENEFICIARY AND ASSIGNMENT PROVISIONS APPLICABLE TO BENEFITS FOR LOSS OF LIFE .. 28

ADDITIONAL PROVISIONS FOR BENEFITS OTHER THAN LIFE INSURANCE 30

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 32

BENEFITS FUNDED BY IMPERIAL PALACE, INC. V.E.B.A TRUST 33

PLAN SUMMARY 34

MEDICAL BENEFITS FOR YOU AND YOUR DEPENDENTS 37
Deductible Amount 37
Benefit Limits 38
Pre-Admission Review 38
Covered Expense 39
Covered Expense Does Not Include 41
Pre-Existing Condition Limit 43
Extension of Benefits During Disability 43

MEDICAL BENEFITS CONVERSION RIGHT 44

DENTAL EXPENSE BENEFITS 46
Dental Cash Deductible 46
Covered Dental Expense 46
Dental Exclusions 46
Extension of Benefits 48

TABLE OF ALLOWANCES 49

COORDINATION OF MEDICAL AND DENTAL BENEFITS 53

REPLACEMENT OF COVERAGE 56

ADDITIONAL PROVISIONS 58

SUMMARY PLAN DESCRIPTION 61
Claims Procedure 62
ERISA Rights 64

INTRODUCTION

The text on the pages which follow describes your Life, Accidental Death and Dismemberment, Medical and Dental Plans and includes the limitations and all other provisions which apply to you.

Your Plan Booklet is divided into three parts. The first part describes definitions, eligibility, and termination provisions, which apply to all coverages. The second part describes Group Life Insurance and Accidental Death and Dismemberment Benefits which are underwritten by Provident Life & Accident Insurance Company. The third part outlines and describes the Medical and Dental Benefits which are funded by Imperial Palace, Inc. V.E.B.A. Trust

- With respect to definitions, eligibility, and termination, provisions, any reference to dependents' coverage applies to you only if you have dependents covered under the *Plan*.
- With respect to your Group Life Insurance and Accidental Death and Dismemberment Benefits, the insured *member* is referred to as "you" and Provident Life & Accident Insurance Company is referred to as "we", "our", or "us".
- With respect to Medical Benefits, the *covered person* is referred to as "you", and Imperial Palace, Inc. V.E.B.A. Trust is referred to as "we", "our", or "us".

All *italicized* words have specific definitions. These definitions can be found either in the **Definitions** sections or in the same section where the italicized term is used.

* * *

COVERED EXPENSE

Subject to the section entitled **Covered Expense Does Not Include**, Covered Expense shall include only the charges for the services and supplies listed below which: (1) Are furnished to a *covered person* for diagnosis or treatment of an *illness*; (2) Are of the usual type furnished for such purpose; (3) Do not exceed the usual and customary charges within the area in which the expense is incurred; and (4) Have been authorized by a *doctor*.

- Services and supplies which are furnished by, and fall within the scope of the authorized practice of, a *health care provider*, provided that:

  - For *hospital* room and board, Covered Expense for any day shall not exceed the *hospital's* most common semi-private room daily rate. However, this limit: (1) Shall not apply to a unit for intensive or specialized care; and (2) Shall be changed to the most common private room daily rate when a private room is used on order of a *doctor* or because the *hospital* is not equipped with semi-private rooms.

  - Covered Expense for any day of confinement in a *nursing home* shall not exceed 50% of the average semi-private room daily rate for *hospitals* in the area in which the *nursing home* is located. *Nursing home* confinement must start within seven days after *hospital confinement* ends.

  - Covered Expense includes charges for a *birthing center* provided that such coverage shall cease at the end of a 24 hour period following the birth of the child.

– Covered Expense includes charges for hospice care made by a *hospice* only if: (1) The expense is incurred by a *covered person* diagnosed by a *doctor* as terminally ill with a prognosis of six months or less to live; and (2) The *hospice* provides a plan of care which: (A) Is prescribed by the *doctor;* (B) Is reviewed and approved by the *doctor* monthly; (C) Is not for any curative treatment; (D) States the belief of the *doctor* and the *hospice* that the hospice care will cost less in total than any comparable alternative to hospice care; and (E) Is furnished to the *Claims Administrator.*

* * *